APRIL 2008

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Attachment #3

Wow! What a busy start to 2008! I have recently completed nine (9) regional OASIS trainings for a total of *514* people trained. The areas where I trained were St. Louis (2 trainings), Cape Girardeau, Hannibal, Moberly, Columbia, Kansas City, Springfield, and Joplin. I hope your agency was able to take advantage of this opportunity. In the future I hope to have all the materials that were handed out at the trainings available on our website. This will take some time but are hopeful that by the end of June these will be available. Our website is www.dhss.mo.gov/HomeCare.

For those of you who attended the trainings, you are aware that there are a number of questions that I may not have been able to answer at that time. These questions are being compiled and forwarded to CMS for official answers. I had hoped to have them compiled, answered, and available for this publication but was unable to meet that deadline. As you are aware I have other responsibilities in the Bureau other than OASIS. Therefore, it will likely be with the next quarterly Bureau Talk, that these questions and answers are distributed. If they are available sooner they will also be put on our website.

At this time no further training is being planned for this calendar year. However, as usual, if you or any of your staff have any OASIS questions, do not hesitate to contact me at 573-751-6336.

The CMS Quarterly OCCB (OASIS Certification Competency Board) Q&As for April 2008 has been published. **(Please see Attachment #4).** Discussing these latest Q&As with your staff would make a great in-service topic! These Q&As and all the past OCCB Q&As can be found at http://www.oasiscertificate.org.

There have been a couple OASIS issues that I have received clarification on that are different than what I presented in my trainings. I have listed those Q & A's on the following pages. (This is not the complete list of Q & As that I am compiling from the training.) Please be sure your staff is made aware of these. This will be different guidance than what was discussed at the trainings and what they may find in the OASIS training manuals. This is a perfect example of how things are forever changing in the "OASIS world." It is imperative that your agency develop a way of keeping up on the latest OASIS information. Discussing these few particular questions and answers would also make another good in-service for your staff!

CLARIFICATION OF SEVERAL Q & As – APRIL 2008

1) **Comprehensive Assessment/Drug Regimen Review** – If the physical therapist does the SOC Comprehensive Assessment, how long does the RN have to do the Drug Regimen Review?

   ANSWER: CFR 484.55(b) Tag G334 *Completion of the comprehensive assessment* states "The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care." CFR484.55(c) Tag G337 *Drug Regimen Review* states "The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy." This requirement applies to all patients being serviced by the HHA, regardless of whether the specific requirements of OASIS apply.

   In summary**,** the drug regimen review by the registered nurse, in a therapy only case, must be done consistent with the patient's needs but no later than 5 calendar days after the start of care.

2) **M0090** Should the M0090 date be changed when a correction is made after a clinician has completed the assessment but before the assessment is locked? For example, the nurse completes the assessment with a M0826 response of 3 visits on February 1st and records that date at M0090. On Feb 2nd the nurse learns that the therapist assessed the patient and received physician orders for 10 therapy visits. Should the M0090 date be changed to February 2nd to reflect the date that M0826 is corrected?

   ANSWER: If the original assessing clinician gathers additional information during the SOC 5-day assessment time frame that would change a M0 item response, the M0090 date would be changed to reflect the date the information was gathered and the change was made. If an error is identified at any time, it should be corrected following the agency's correction policy and M0090 would not necessarily be changed. ***(April 2008 CMS OCCB Q&As)***

3) **M0110** How do you answer M0110 if the patient's payer source is a Medicare HMO (Non-Medicare PPS payer) that requires a HHRG? What if the payer source is a Medicare HMO (Non-Medicare PPS payer) that does not require a HHRG?

   ANSWER: For a Medicare HMO payer that requires an HHRG/HIPPS, mark UK For a Medicare HMO payer that does not require an HHRG/HIPPS, mark NA. ***(April 2008 CMS OCCB Q&As)***

4) **M0110** How do you answer M0110 at Resumption of Care (ROC)?

   ANSWER: M0110 is an OASIS item with a single use of facilitating payment under the Home Health Prospective Payment System. Typically, at the SOC

(RFA 1) and Recertification (RFA 4), data from Mo110 (along with other relevant OASIS items) are used to determine the payment under PPS for the current or upcoming episodes respectively. In addition to SOC and Recert, M0110 is also collected at the ROC (RFA 3) time point. Typically, data from this ROC is not used for PPS payment determination, and in cases where the data is not needed for payment, response NA –Not Applicable: No Medicare case mix group to be defined by this assessment could be reported on M0110.

Alternatively, upon ROC, providers may choose to report the same Mo110 response that was reported at the SOC (or Recert) assessment that began the current episode, or they could report UK – Unknown. If the ROC assessment will not be used to determine payment, then it does not matter which of the above approaches an agency chooses.

While data from the ROC time point does not usually affect PPS payment, there is a specific situation in which it does; that is when a patient under an active home health plan of care is discharged from an inpatient facility back to the care of the home health agency in the last five days of the certification period. In that situation, CMS allows the agency to complete a single ROC assessment to meet the requirements of both the resumption of care and of the pending recertification. When a ROC assessment will be "used as a recert" (i.e., used to determine payment for the upcoming 60-day episode), then the ROC data will be necessary to define a case mix (payment) group, in which case if Medicare PPS is a payer; mark 1-Early if the upcoming episode is the 1st or 2nd adjacent episode, mark 2-later if the upcoming episode is the 3rd or > adjacent episode, mark UK if you don't know and/or will not be making efforts to find out. ***(CMS OCCB Q&As, April 2008)***

5) **M0540** If a patient has bowel incontinence in response to a bowel training program would that patient be considered incontinent of bowel?

ANSWER: Yes, this patient would be incontinent. If the patient cannot voluntarily hold the bowel until able to get on bedpan or to the toilet he/she would be considered incontinent of bowel.

6) **M0800** If a patient is receiving injections at her physician's office; do we include those injections when answering this M0 item?

ANSWER: When a patient is receiving an injectable medication in the physician's office or other setting outside the home, it is NOT included in the assessment of M0800, Management of Injectable Medications.

M0800, Management of Injectable Medications, reports the patient's ability to prepare and take (inject) all prescribed injectable medications that the patient is receiving in the home while under the home health plan of care. M0800 requires an assessment of the patient's cognitive and physical ability to draw up the correct dose accurately using aseptic technique, inject in an appropriate site using correct technique, and dispose of the syringe properly.

M0800 includes all injectable medications the patient has received or will receive in the home during the home health plan of care for the "current" status, and 14 days prior to the SOC/ROC date for the "prior" status. Note that if an injectable medication is given by a nurse, the clinician will need to determine if the administration by the nurse was for convenience, or if administration by the nurse was ordered by the physician which represents a medical restriction inferring that the patient is unsafe/unable to self-inject. If that is the case, the appropriate response for M0800 would be 2- Unable to take injectable medications unless administered by someone else.

M0800 would also include one- time injections that were ordered to occur in the home as long as the administration occurred during the period of time covered by the plan of care. If the patient administered the medication, the clinician would report the patient's ability to complete the included tasks on the day of the assessment. If the injection was ordered but not to be administered on the clinician's day of assessment, the clinician will use the assessment of the patient's cognitive and physical ability and make an inference regarding what the patient would be able to do. ***(CMS OCCB Q&As, April 2008)***

7) **M0826** Please explain how to answer M0826 at ROC (Resumption of Care)?

ANSWER: M0826 is an OASIS item with a single use of facilitating payment under the Home Health Prospective Payment System. Typically, at the SOC (RFA 1) and Recertification (RFA4), data from M0826 (along with other relevant OASIS items) are used to determine the payment under PPS for the current or upcoming episodes respectively. In addition to SOC and Recert, M0826 is also collected at the ROC (RFA3) time point. Typically, data from this ROC is not used for PPS payment determination, and in cases where the data is not needed for payment, response NA –Not Applicable: No case mix group defined by this assessment could be reported on M0826. Alternatively, providers may choose to report the total of therapy visits that have been provided during the episode to date, added to the number of therapy visits planned to be provided during the remainder of the current episode. If the ROC assessment will not be used to determine payment, then it does not matter which of the above approaches an agency chooses.

While data from the ROC time point does not usually affect PPS payment, there is a specific situation in which it does; that is when a patient under an active home health plan of care is discharged from an inpatient facility back to the care of the home health agency in the last five days of the certification period. In that situation, CMS allows the agency to complete a single ROC assessment to meet the requirements of both the resumption of care and of the pending recertification. When a ROC assessment will be "used as a recert" (i.e., used to determine payment for the upcoming 60 day episode), then the ROC data will be necessary to define a case mix (payment) group, in which case the total number of therapy visits planned for the upcoming 60-day episode should be reported. ***(CMS OCCB Q&As, April 2008)***